

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 28000

National Office of Vital Statistics

FILED AUG 26 1947

Registration District No. 779

Primary Registration District No. 1002

Registrar's No. 3417

1. PLACE OF DEATH:

(a) County: JACKSON
(b) City or town: KANSAS CITY
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
904 EAST-77TH STREET
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 25 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: MISSOURI (b) County: JACKSON 48
(c) City or town: KANSAS CITY 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 904 EAST-77TH STREET 8
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: _____

3. (a) PRINT FULL NAME: Miss ALICE WILLIAMS

3. (b) If veteran, name war: No
3. (c) Social Security No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6. (a) Single, widowed, married, divorced: SINGLE
6. (b) Name of husband or wife: _____
6. (c) Age of husband or wife if alive: _____ years
7. Birth date of deceased: JUNE 9 1862 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
85 1 29 hr. min.

9. Birthplace: UNKNOWN OHIO (City, town, or county) (State or foreign country)

10. Usual occupation: AT HOME

11. Industry or business: _____
12. Name: DAVID WILLIAMS
13. Birthplace: OHIO (City, town, or county) (State or foreign country)
14. Maiden name: MARGARET JONES
15. Birthplace: MARYLAND (City, town, or county) (State or foreign country)

16. (a) Informant: Miss CHRISTINE REEVES
(b) Address: 904 EAST-77TH STREET

17. (a) BURIAL (Burial, cremation, or removal)
(b) Date thereof: AUG-11-1947 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. MORIAN CEMETERY

18. (a) Signature of funeral director: J. H. Newsumers Sons
(b) Address: 1401 BRUSH CREEK BLVD.

19. (a) 8-11-47 (Date received local registrar)
(b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: AUGUST day: 8TH year: 1947 hour: 4 minute: 21 P. M.

21. I hereby certify that I attended the deceased from 8-2-47 (1947) to 8-8-47 (1947) that I last saw her alive on 8-8-47 and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis

Due to: Arteriosclerosis

Due to: _____

Other conditions: _____ (Include pregnancy within 3 months of death)

Major findings: Of operations: _____

Of autopsy: _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify): No

(b) Date of occurrence: _____
(c) Where did injury occur: _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____ (Specify type of place)
While at work? _____ (e) Means of injury: _____

23. Signature: J. R. [Signature] (M. D. or other)
Address: 25th & Troost, A.C.M.O. Date signed: 8-9-47

Duration: 1 yr

PHYSICIAN

Underline the cause of which death should be charged statistically.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed Edward M. Storey

Licensed Embalmer No. 4452

P. O. Address K.C. 4 mi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.